STATE OF WASHINGTON

Medicaid Section 1115 Demonstration Waiver Application

Washington State Medicaid and SCHIP Reform Waiver

Department of Social and Health Services
Dennis Braddock, Secretary

Medical Assistance Administration
Tom Bedell, Acting Assistant Secretary

DRAFT

October 17, 2001

TABLE OF CONTENTS

SECTIONS **PAGE**

EXECUTIVE SUMMARY (To be added)

I. Introduction 1
II. Washington State's Low-Income Health Programs 2
Medical Assistance Programs 2
Basic Health Program 3
III. Washington State's Strategy to Offer Health Care for Low-income Residents 3
A Bellwether State 4
Children's Coverage 5
Coverage for Low-Income Working Individuals and Families 7
Other Vulnerable Populations 8
Managed Care – Improving Access and Quality for Families and Children 9
IV. Fiscal Environment 10
Revenue Sources 10
Expenditure History 13
V. Demonstration Design 21
Core Vulnerable Population Coverage 22
Cost-Sharing 22
Benefit Package Flexibility 24
Enrollment Limits 26
Coverage for Parents with Medicaid and SCHIP Children 27
VI. Requested Waivers 28
Copayments 28
Premiums 29
Benefit Package 29
Enrollment Limits 30
VII. Program and Demonstration Administration 31
Single State Agency 31
Program Administration 32
Demonstration Administration 32
VIII. Demonstration Evaluation 33
Demonstration Goals 33
Demonstration Objectives 33
Demonstration Evaluations 34
IX. Budget and Allotment Neutrality 38
Title XIX Budget Neutrality 38
Title XXI Allotment Limits 38
X. Other Assurances 39
XI. Public Process 39

ATTACHMENTS

A. **Overview of MAA and Basic Health Programs**
B. **2001 Basic Health Member Handbook**
C. **Actuarial Comparison of Benefit Design Floor with Uniform Medical Plan and Basic Services**
D. **Actuarial Comparison of Basic Health with Uniform Medical Plan**
E. **Title XXI Allotments & Expenditure Estimates**
F. **Basic Health Program Expansion Estimates**
G. **DSHS & MAA Organizational Charts**

I. INTRODUCTION

The Washington State Department of Social and Health Services (DSHS) is requesting authority under Section 1115(a) of the Social Security Act to implement a demonstration waiver that will allow the state more flexibility to administer its Medicaid program. This Medicaid and State Children's Health Insurance Program (SCHIP) Reform Waiver would help the state sustain its existing coverage for low-income children and other vulnerable populations covered under its Medicaid optional programs. Washington State also is requesting the demonstration waiver to use its unspent Title XXI SCHIP allotment to expand coverage to parents with Medicaid and SCHIP children, and childless adults on a lower priority basis.

Washington is requesting a unique demonstration waiver. The waiver would allow the State programmatic flexibility to adopt cost-sharing, benefit design flexibility, and enrollment cap options for its Medicaid Categorically Needy and Medically Needy optional programs. Unlike other demonstration waivers that adopt changes at the beginning of their waiver period, Washington would only adopt these programmatic changes if they are needed to help sustain coverage.

Washington's waiver also differs from other demonstration waivers in that it is not proposing to make Title XIX funding available for new expansion populations. Any changes in program coverage would only be those allowed under Medicaid law.

The requested programmatic flexibility is not open-ended. Washington's demonstration waiver includes limits on the options to ensure that its vulnerable populations continue to have access to medically appropriate care. These changes would require approval by the Washington State Legislature and review by the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS) to ensure that the program changes are consistent with the demonstration waiver's terms and conditions.

In addition to sustaining its existing Medicaid coverage limits, Washington's demonstration is requesting authority to use its unspent Title XXI SCHIP allotment to expand coverage through its Basic Health (BH) program for parents with Medicaid and SCHIP children, and childless adults on a lower priority basis. This expansion would allow the state to combine federal and state funds to make available additional BH slots. This coverage expansion would be limited to the unspent Title XXI allotment and would ensure allotment neutrality. Expansion would begin in January 2003, or as soon as administratively possible thereafter.

As described in the application, Washington's demonstration waiver builds upon its existing state-subsidized programs for low-income residents, including its Medicaid, SCHIP and state-only funded programs. The requested program flexibility builds upon and is consistent with both Congressional and CMS strategies to offer coverage to low-income children and families. The request also builds upon the National Governors' Association (NGA) HR-32 Health Reform Policy and the Administration's recently announced Health Insurance Flexibility and Accountability (HIFA) demonstration initiative.

II. WASHINGTON STATE'S LOW-INCOME HEALTH PROGRAMS

MEDICAL ASSISTANCE PROGRAMS

Washington State's Department of Social and Health Services (DSHS) administers seven health care programs through its Medical Assistance Administration (MAA). These include: Medicaid Categorically Needy (CN) program, Medicaid Medically Needy (MN) program, State Children's Health Insurance Program (SCHIP), Children's Health Program (CHP), Medical Care Services Program, Medically Indigent (MI) program, and Refugee Assistance medical coverage.

In July 2001, these programs covered 829,900 residents, and an additional 30,700 persons receiving family planning coverage - nearly 14 percent of all residents in the state. The MAA programs were providing coverage to 529,600 children – 33 percent of all children in the state.

Washington's Medicaid CN Mandatory programs provide coverage to 625,300 persons – 73 percent of all Medical Assistance coverage. CN categorical eligibility groups include: low-income families with dependent children meeting TANF income limits (45 percent of the federal poverty level - FPL), low-income elderly and disabled persons who qualify for Supplemental Security Income (SSI), pregnant women and infants in families up to 185 percent of FPL, children through age 5 with incomes up to 133 percent of FPL, and children through age 18 with incomes up to 100 percent of FPL.

Washington's Medicaid optional programs offer coverage to 155,700 persons plus 30,700 receiving family planning-only coverage - 22 percent of all Medical Assistance coverage. These optional programs provide coverage to: children with incomes up to 200 percent of FPL, low-income elderly and disabled persons who do not receive SSI grants or who have incomes up to 300 percent of the SSI grant standard and need institutional level of care, uninsured women up to 200 percent of FPL with breast and

cervical cancer, working disabled persons with incomes up to 450 percent of FPL, and Medically Needy elderly and disabled persons with incomes above CN standards.

Washington also offers coverage to children in families up to 250 percent of FPL through its SCHIP program. Currently, some 4,500 children in moderate-income families are receiving coverage through this program.

In addition to its Medicaid programs, DSHS provides coverage to over 44,300 low-income residents through its state-funded medical programs. This includes low-income children who do not meet federal citizenship requirements, persons with physical and mental health incapacities that make them unemployable, and other low-income uninsured persons with an emergent medical condition requiring hospital care.

BASIC HEALTH PROGRAM

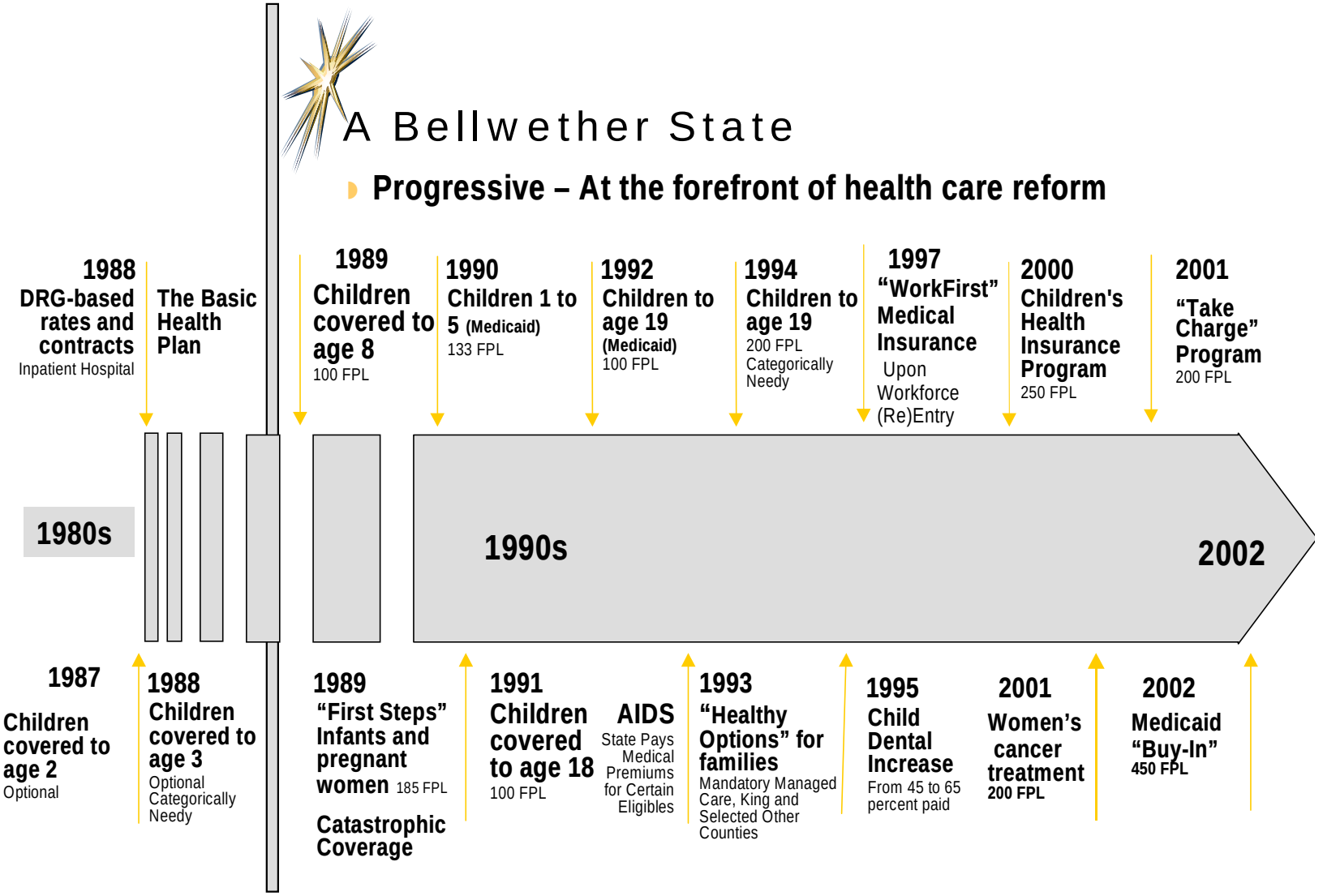
The state's Health Care Authority (HCA) administers the Basic Health (BH) program. HCA also purchases health care coverage for state employees, retirees and other local governmental entities.

The BH program offers subsidized, basic comprehensive coverage to individuals and families with incomes up to 200 percent of FPL. For state fiscal year (SFY) 2002, BH is authorized to cover 125,000 persons.

Attachment A provides a detailed description of the state's Medical Assistance and BH programs. It is important to know about these programs, as it helps explain the extraordinary commitment that Washington has made in providing both federal and state-only programs for its low-income residents. These programs are providing coverage to 16 percent of all Washington residents. The children's programs are providing coverage to 33 percent of all children in the state.

III. WASHINGTON STATE'S STRATEGY TO OFFER HEALTH CARE FOR LOW-INCOME RESIDENTS

Washington State has been a national leader in expanding health care coverage to children, targeted vulnerable populations, and other low-income residents. Unlike other 1115 demonstration states, Washington has built its expansion initiatives upon its existing Medicaid program and its state-only programs, such as the BH program. The following exhibit illustrates the changes that have made Washington a bellwether state with its progressive initiatives in health care reform.


A Bellwether State
Progressive – At the forefront of health care reform
1988
DRG-based rates and contracts
Inpatient Hospital
The Basic Health Plan
1989
Children covered to age 8
100 FPL
1990
Children 1 to 5 (Medicaid)
133 FPL
1992
Children to age 19 (Medicaid)
100 FPL
1994
Children to age 19
200 FPL
Categorically Needy
1997
"WorkFirst" Medical Insurance
Upon Workforce (Re)Entry
2000
Children's Health Insurance Program
250 FPL
2001
"Take Charge" Program
200 FPL
1980s
1990s
2002
1987
Children covered to age 2
Optional
1988
Children covered to age 3
Optional
Categorically Needy
1989
"First Steps" Infants and pregnant women 185 FPL
Catastrophic Coverage
1991
Children covered to age 18
100 FPL
AIDS
State Pays Medical Premiums for Certain Eligibles
1993
"Healthy Options" for families
Mandatory Managed Care, King and Selected Other Counties
1995
Child Dental Increase
From 45 to 65 percent paid
2001
Women's cancer treatment
200 FPL
2002
Medicaid "Buy-In"
450 FPL

Children's Coverage

In the late 1980s, Washington began to implement a series of medical care coverage expansions for children. In 1989, the State Legislature enacted the Maternity Care Access Act of 1989. This act authorized DSHS to expand Medicaid coverage and provide comprehensive prenatal care coverage to pregnant women and infants with incomes up to 185 percent of FPL.

In January 1991, DSHS implemented the Children's Health Program to provide coverage to children under age 18 who were in families with income up to 100 percent of FPL. The state's Medicaid program was already covering children through age 5 in families up to 133 percent of FPL. The Children's Health Program was converted to Medicaid funding in January 1992, and the age limit was raised through age 18.

Children not meeting Medicaid citizenship requirements continued to receive coverage through the Children's Health Program. This program now offers health care to some 19,500 children who do not qualify for Medicaid.

In July 1994, the Medicaid children's program was further expanded to 200 percent of FPL. This expansion was part of comprehensive health reform legislation that was intended to require that all residents be enrolled in health insurance. The reformed system would continue to be based on employer-sponsored coverage. However, the state would provide subsidized coverage to residents up to 200 percent of poverty.

Prior to enactment of SCHIP, Washington was one of only four states with optional Medicaid coverage at or above SCHIP's target coverage of 200 percent of FPL. In February 2000, Washington extended coverage up to 250 percent of FPL through SCHIP. Washington is one of ten states with children's coverage at or above 250 percent of FPL.

In July 2001, Washington's Medicaid programs provided coverage to 503,900 children - about 177,500 received coverage through Family (TANF) Medical; 14,200 were disabled children receiving SSI assistance; 178,000 were covered through the Medicaid mandatory children's program; and 132,700 were covered through Medicaid optional program coverage.

In total, the Medical Assistance and BH programs cover about 538,000 children. This is over 33 percent of all children in the state.

MAA adopted a series of innovations to make accessing health care coverage easier. These included: simplifying the eligibility application forms, eliminating family resource requirements, and implementing a mail-in application process through a centralized eligibility unit.

These coverage expansions and eligibility innovations have played a key role in reducing children's uninsured rates. Washington's uninsured rate continues to decline. Based on the most recently available data, Washington's children had an uninsured rate of 7.2 percent in 2000.[1] The uninsured rate for children below 200 percent of FPL was 13.8 percent.

According to Kaiser Family Foundation's State Health Facts, Washington had the 12th lowest uninsured rate for children, based upon the most recent pooled period from the U.S. Census Bureau's Current Population Survey (CPS).[2] The 1997-99 CPS pooled data indicates Washington had the seventh lowest low-income children's uninsured rate (13.7 percent) in the country, compared to a national rate of 24.0 percent.[3]

Based on the Urban Institute's National Survey of America's Families, Washington's 1999 children's uninsured rate (7.5 percent) ranked fifth among the 13 states.[4] The national rate was 12.5 percent. Washington had the lowest uninsured rate (11.2 percent) for children in families below 200 percent of FPL. This compared to a national rate of 22.4 percent.

In addition to expanding health care coverage, Washington has undertaken a set of initiatives to improve children's health status through the Medicaid-financed First Steps program implemented in 1989. The goal of the First Steps program is to ensure healthy birth outcomes for low-income families.[5] Access to essential prenatal care has improved through this program. The rate of inadequate prenatal care (third trimester entry or none) for Medicaid women dropped 57 percent from 10.9 percent in 1989 to 4.7 percent in 1999. In comparison, the rate for non-Medicaid women dropped 59 percent from 3.2 percent to 1.3 percent over the same period.

Birth weight is a primary indicator of the health of the newborn infant. Through the First Steps program the incidence of low birth weight (less than 2500 grams or 5.5 pounds) decreased 24 percent for Medicaid infants, from 7.0 percent in 1989 to 5.3 percent in 1999. In comparison, the rate for non-Medicaid infants averaged about 3.6 percent over the eleven-year period.

---

[1] Source: 2000 Washington State Population Survey. Washington State Office of Financial Management (July 15, 2001 Preliminary Analysis).
[2] Source: The Kaiser Family Foundation's State Health Facts Online.
[3] Source: U.S. Census Bureau – Low Income Uninsured Children By State: 1997,1998, 1999.
[4] Source: Urban Institute's National Survey of America's Family. Snapshots of America's Families II. National survey plus 13 state-specific surveys: Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.
[5] Source: **The First Steps Program: 1989-1997**, Cawthon, Laurie, Report Number 7.99, Department of Social and Health Services (July 1999). **State of Washington – First Steps Database**, Characteristics of Women Who Gave Birth in Washington State for 1989 through 1998, Cawthon, Laurie, (March 29, 2000).

The First Steps program helped reduce the incidence of infant mortality. Infant mortality decreased by 62 percent, from 15.2 deaths per 1,000 live births before First Steps (1988-89) to 5.8 deaths per 1,000 after First Steps (1998) for Medicaid women covered under the expansion program. Although the decrease (25 percent) for AFDC women from 13.1 deaths per 1,000 to 9.8 deaths per 1,000 was less than either the expansion group or the statewide average of 30 percent, it is a marked improvement.

Currently, the Medicaid program covers more births (41 percent) than any other payer. The coverage rate has increased 50 percent, from 27.3 percent in 1989 to 41.0 percent in 1999. In an effort to reduce unintended pregnancies, MAA has been partnering with the Department of Health to develop pregnancy education and prevention strategies. In July 2001, DSHS implemented an 1115 demonstration project, called Take Charge, that offers Medicaid-financed family planning and education services to all women and men in families at or below 200 percent of FPL.

Coverage for Low-Income Working Individuals and Families

Washington also has been a national leader in offering innovative health care coverage to families and individuals through the BH program. Based on a 1986 study by the Washington Health Care Project Commission, the 1987 State Legislature enacted legislation and funding for BH and the Washington State Health Insurance Pool (WSHIP). BH was implemented in 1988 as a managed care demonstration project. The Legislature originally gave funding authority to cover up to 22,000 residents with incomes up to 200 percent of FPL.

As part of its 1993 comprehensive health reform legislation, the Legislature expanded BH into a permanent program, lifted the enrollment cap, and merged it with the state's Health Care Authority (HCA), which is responsible for purchasing health care insurance for state employees and other local governmental employees. The Legislature also created the Health Services Account (HSA) to fund BH, public health and other health initiatives.

In 1995, the Legislature authorized that coverage would be expanded to include mental health, chemical dependency and organ transplants. Funding also was provided to restructure the BH premium to be more affordable. Nearly 130,000 residents annually received subsidized BH coverage from October 1996 through 2000. See Attachment B for a more detailed description of the BH program contained in the 2001 Basic Health Member Handbook, including benefit coverage and cost-sharing requirements. (There are minor changes for 2002 that will be included in the new Member Handbook.)

Although health care costs have increased at a greater rate than revenue growth, the 1999 Legislature authorized funding to cover 133,000 BH enrollment slots for the

1999-2001 biennium. The 2000 Legislature enacted legislation that would allow BH to increase the allowable income level up to 250 percent of FPL if federal funding is made available to help finance the expansion. Due to continued growth in health care costs, the 2001 Legislature appropriated an additional increase in funding. However, the funding is intended to cover only about 125,000 enrollees. HCA will be managing BH enrollment to achieve this target through attrition.

HCA and DSHS have undertaken a number of initiatives to create seamless coverage for families eligible for BH and Medicaid coverage. In 1994, the agencies implemented Basic Health Plus (BH+), whereby Medicaid eligible children with BH parents could be in the same managed care plan as their parents and receive free, full-scope Medicaid coverage. HCA contracts for both BH and BH+ coverage and receives Medicaid payments from DSHS for the children's coverage. The two agencies coordinate so that families only have to apply through HCA to obtain BH and BH+ coverage. Currently there are 56,000 Medicaid children in BH+. In addition, eligible pregnant women receive free, full-scope Medicaid medical and prenatal care coverage through their BH plan for up to 60-days post partum.

Other Vulnerable Populations

Washington has used its Medicaid optional programs and state-only funded programs to cover vulnerable populations. Washington is one of 23 states with a Medically Needy program. This program offers coverage to elderly and disabled persons. Coverage is also offered to persons with less severe disabilities through the state-administered Medical Care Services program. Persons with a physical, mental impairment or substance abuse addiction that makes them unable to have gainful employment are thereby able to have health coverage. The Medically Needy and Medical Care Services programs are currently providing coverage to some 27,000 elderly and disabled programs.

Washington has more recently sought to offer health coverage to two other groups. In July 2001, Medicaid coverage was extended to uninsured women with incomes up to 200 percent of FPL, ages 40 through 64, with breast or cervical cancer diagnosed by screening through the Washington State Breast and Cervical Health Program. At this time, Washington is one of only 19 states offering this optional coverage.

The 2001 Legislature authorized funding for DSHS to implement a Medicaid Buy-In program for the working disabled. Coverage will be offered to persons with incomes up to 450 percent of FPL. The program is scheduled to begin offering coverage in January 2002.

For a number of years, Washington has also offered coverage through its Medically Indigent program to low-income uninsured persons faced with an emergent medical condition requiring hospital care. This program, in conjunction with the state's Disproportionate Share Hospital (DSH) programs, provides critical funding to Washington hospitals that serve Medicaid and other low-income residents.

Managed Care – Improving Access and Quality for Families and Children

MAA has adopted managed care as one strategy to increase access, provide medical case management and promote cost-containment. MAA has historically contracted with health plans to provide voluntary coverage to Medicaid families since the 1970s. In 1986, mandatory enrollment for Medicaid families and children was introduced in Kitsap County and later expanded to Mason and Jefferson counties.

The Healthy Options (HO) program was started in Spokane County in July 1992. Later, as part of statewide health reform, MAA began a major initiative to expand the program statewide. This was achieved by July 1995.

HO mandatory coverage is required for TANF families, pregnant women, and Medicaid eligible children. However, American Indian and Alaska Natives are also able to get primary care case management (PCCM) through their tribal or Indian Health Services' clinics.

MAA and the Health Care Authority (HCA) jointly developed the Basic Health Plus (BH+) program whereby children in families obtaining subsidized BH coverage could remain in their parent's plan and obtain free, full-scope Medicaid coverage. Currently, there are some 56,000 BH+ children enrolled with their parents in BH.

MAA and HCA contract with many of the same health carriers. To reduce the administrative burden on carriers, MAA and HCA have adopted a common set of quality assurance requirements based on the National Committee on Quality Assurance's (NCQA) national standards. In partnership with the Department of Health, the two agencies monitor plans together through the TeaMonitor process. The two agencies also use national performance measures to evaluate plans' performance.

In 1998, MAA and HCA began to engage in a joint RFP contracting process for HO, BH and coverage for the Public Employees Benefits Board (PEBB). This joint endeavor reduces both health carrier and agency administrative burden and was intended to increase the agencies' purchasing power.

Currently, MAA is contracting with seven health carriers and HCA and has some 418,000 individuals enrolled in managed care. In the majority of counties, enrollees

have a choice of two or more plans. There are 11 single-plan counties in which enrollees may choose the fee-for-service delivery system as an alternative. There are two counties with multiple plans that are at enrollment capacity, and one county with no plan available, resulting in no alternative to the fee-for-service delivery system.

MAA is currently conducting a Request for Information (RFI) to obtain information about current disease management projects throughout the United States. After responses to the RFI are submitted, staff will analyze the information submitted in order to establish a framework within which to issue a formal Request for Proposals (RFP). The RFP will result in one or more contracts to provide disease management programs that will result in better-coordinated care for Medicaid clients not eligible for Healthy Options. This group includes SSI recipients and others identified by MAA as having health conditions that would benefit from increased coordination of care.

IV. FISCAL ENVIRONMENT

Washington State is facing a fiscal crisis in being able to sustain state commitments for education, health care for low-income residents, essential social services for vulnerable populations, and other services that are the state's responsibility. Unlike other states, Washington has both revenue and spending limits that contribute to this challenge. The state's expenditure limits place a significant constraint on state financed health care coverage because these limits have historically been below basic health care inflation.

Revenue Sources

Washington's Medical Assistance programs are financed through a combination of federal Medicaid and SCHIP funds, funds from the State General Fund, the Health Services Account (HSA), and local intergovernmental funds. Expenditures from the State General Fund, the HSA, and local intergovernmental funds are matched by federal funds. The federal contribution will be about 49 percent, HSA 11 percent, and local funds approximately 4 percent of expenses for Medical Assistance programs.

The State General Fund provides approximately 36 percent of the funding for Medical Assistance programs. However, State General Fund dollars are not unlimited. Washington's State General Fund expenditure growth is limited under Initiative 601. Enacted in 1993, I-601 limits state expenditure growth after July 1995 to an annual fiscal growth factor. The expenditure limit is based on the previous year's spending level and a growth factor determined by inflation and population changes, with a two-

year lag.[6] During the six-year state fiscal period from 1996 and 2001, the I-601 fiscal growth factor permitted spending growth of 23.5 percent, an annual average of 3.3 percent.

From 1996 through 2001, Washington state's population increased 7.71 percent, an average growth of 1.2 percent per year. During the same period, inflation added 11.5 percent to the market basket of goods and services, selected medical services have increased by 15.2 percent[7] and expenditures for Medical Assistance programs increased by 66 percent, averaging annual increases of 9.8 percent. That means that each year the state's expenditures for medical services to low income people have increased by three-times the I-601 fiscal growth factor rate. During the FY01-03 biennium, expenditures for medical services are expected to increase by nearly 10 percent each year. While the I-601 fiscal growth factor will permit state spending for the 2001-2003 biennium to be 5.78 percent more than expended during the prior two-year period, the 2001 economic recession has reduced the state's revenue forecast by nearly $1 billion. Like other Department of Social and Health Services' administrations, Medical Assistance Administration (MAA) is preparing 15 percent expenditure reduction proposals.

For state fiscal year 2002, ending June 30, 2002, it is estimated that Medical Assistance programs will expend about $3.1 billion for health care. Given that the MAA caseload is driven by state policy directives, increases in health care costs, prescription drugs and other factors that do not directly correlate with fiscal growth factors, it is apparent why expenditures for Medical Assistance programs have become a larger portion of the DSHS budget (now 42 percent, compared with 29 percent in FY95-97).[8]

The Health Services Account (HSA) was established in 1993 as part of a comprehensive state health reform initiative. The HSA was established to finance state-subsidized coverage for low-income persons and expand public health improvement initiatives. Currently, the HSA is being used to fund the subsidized Basic Health Plan (BHP), Medicaid coverage for children, the state Children's Health Insurance Program and nursing home ProShare payments. Annually, about 60 percent of HSA revenues are used for these purposes.

[6] For example, the 2003 growth factor is based on 3-year average (1999, 2000, and 2001). Population change is the percent change in the state's total population as measured by the Office of Financial Management. Inflation is the percent change in the Implicit Price Deflator.

[7] Consumer Price Index for medical services, not including prescription drugs.

[8] From FY96 through FY03, MAA per capita expenditures are expected to have increased by an average of 7.55 percent annually. It is anticipated that during this same period, expenditures for Medical Assistance programs will average an annual increase of 9.7 percent - more than twice the expected 4.1 percent annual growth in General Fund expenditures. Expenditures for Medical Assistance programs have grown from 29 to 42 percent of the DSHS budget (FY95-97 to FY01-03).

Initially, HSA revenues were obtained from a new set of taxes on alcohol and tobacco products and elimination of tax exemptions on non-profit hospitals and health care premiums. More recently, funds from the state's settlement with tobacco manufacturers and intergovernmental transfers (IGT) from public hospital ProShare programs have been earmarked for the HSA.

It is anticipated the revenue stream into the HSA will be fairly flat during FY00-03. This flat revenue stream is attributed to a decline in tobacco revenue due to smoking reduction and little or no growth in liquor revenue. In FY 2000, HSA revenue from taxes, settlement and other payments was $585.7 million. Revenue from the same sources is anticipated to be $633.6 million in FY03. During this four-year period (SFY 2000-2003), HSA revenue is projected to increase an average of 2.75 percent per year. However, principally due to forecasted caseload growth in children's programs, HSA expenditures are projected to increase at a significantly greater rate.

It is not surprising that MAA's caseload growth is greater than the general population growth. The legislature authorized three major expansions of health coverage for low-income children during this past decade. The agency and community-based groups have undertaken outreach initiatives to ensure that all low-income children have access to health care coverage. Enrollment in the children's Medicaid program increased 12.5 percent per year from FY96-01, and is projected to increase an additional 7.5 percent during this biennium.

The MAA caseload has increased at a greater rate than the general population. During the past six years (FY 1996-2001) MAA's caseload increased 3.4 percent per year compared to 1.2 percent growth in state population. Prior to the 2001 economic downturn, accompanied by much higher unemployment and loss of medical coverage, MAA's caseload was projected to increase 2.3 percent per year during this biennium (compared to 1.1 percent for the population generally).

The dramatic changes in health care cost during the most recent several years have made forecasting the direction and magnitude of change a challenge for policy makers. It is clear that MAA caseload has experienced considerable increases during the last six years, and the cost of providing health services has increased even more. While the fiscal growth factor has held the State General Fund expenditures to annual increases averaging 3.3 percent and flat revenue has held the Health Services Account at 2.75 percent yearly growth, MAA expenditures have averaged an annual 9.8 percent increase during FY96-01 (see Figure One).

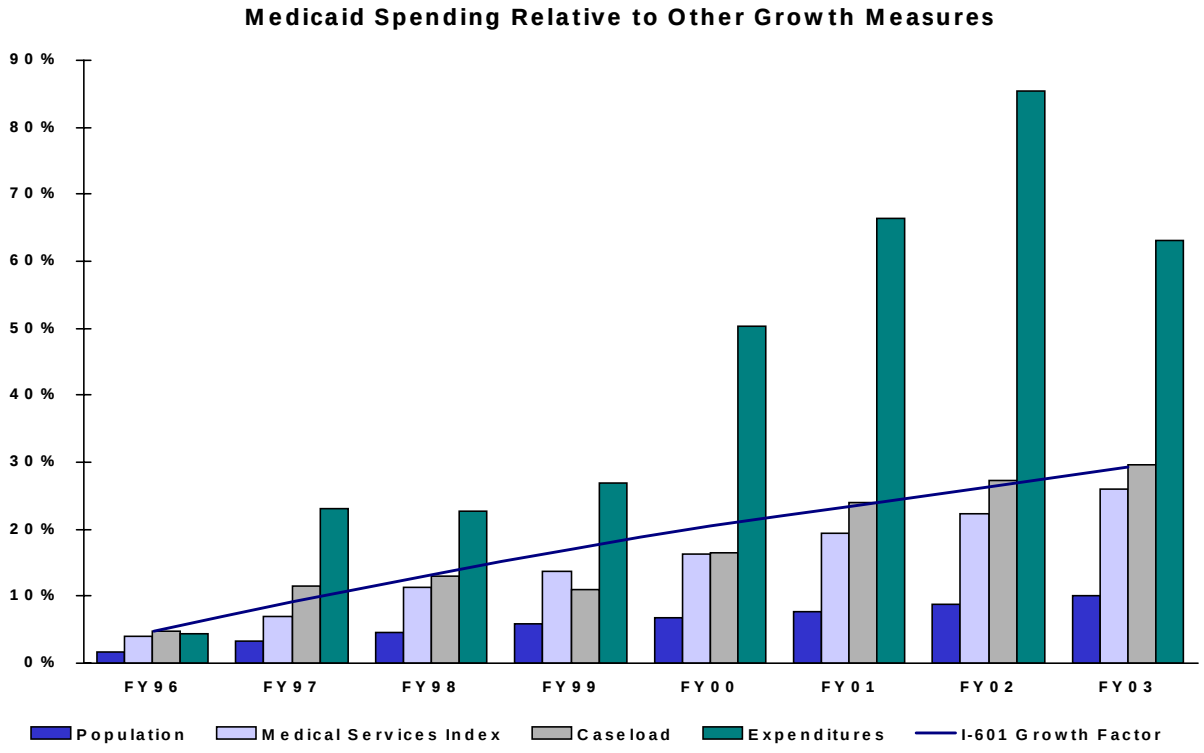


Figure One

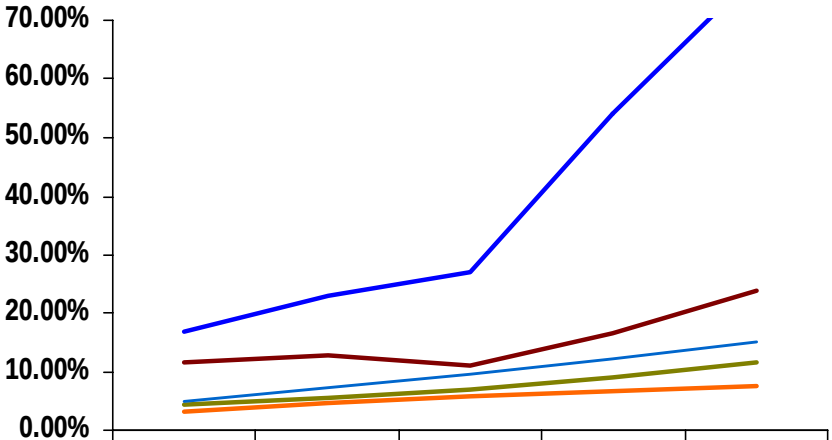
Although the State General Fund expenditure limit and HSA revenues will increase by 5.78 percent and 5.25 percent, respectively, medical assistance expenditures are expected to increase 10.4 percent – more than $1 billion during the FY01-03 biennium. As this gap between available funds and expenditures grows, policymakers must look for additional options to confront this disparity.

Expenditure History

During the 1995-97 biennium DSHS spent $3.03 billion to provide medical assistance for some 680,000 people each month. During the current 2001-03 biennium, DSHS will spend an estimated $6.9 billion to provide coverage to 834,000 people. Medical Assistance programs currently cover 14 percent of all Washingtonians and 33 percent of the state's children. From Fiscal Year 1996 (FY96) through FY 2001, the caseloads for those who are eligible for DSHS Medical Assistance programs have increased by nearly 24 percent.

During this same period, expenditures for Medical Assistance programs have increased by nearly 66 percent (see Figure Two), while the cost for all consumer goods increased 11.5 percent (implicit price deflator) and an index – measuring changes in the cost of providing medical services nationally – increased 15.2 percent from FY96 through FY01.[9] In an effort to better understand what is propelling these considerable cost increases, it is necessary to look as closely as possible at the programs and benefits managed by MAA.

The Growth of Medical Assistance Programs



	FY97	FY98	FY99	FY00	FY01
Expenditures	16.81%	22.99%	27.21%	53.94%	78.03%
Caseload	11.54%	12.93%	11.00%	16.54%	23.97%
Population Change	3.23%	4.63%	5.90%	6.70%	7.71%
Inflation	4.28%	5.65%	7.00%	9.18%	11.53%
Medical Services Index	5.10%	7.20%	9.60%	12.20%	15.20%

Figure Two

Considering all of the expenditures for the services offered by MAA, the five largest categories are: managed care coverage (33 percent), prescription drugs (20 percent),

[9] Office of the Forecast Council, Department of Revenue, Olympia, Washington.

inpatient hospital without DSH payments (17 percent), physician services (8 percent) and outpatient hospital services (6 percent).

While expenditures for these five largest service categories have recorded increases ranging from 11.75 percent per year for prescription drugs to 2 percent for physician services, expenditures for all MAA services have experienced an average annual increase of 9.8 percent per year from FY96 through FY01. This increase is four times the national medical service index increase.

From FY96 through FY01, enrollment in MAA programs has increased slightly more than 18 percent with the addition of 125,000 persons. Nationally, enrollment in Medicaid programs increased 4.3 percent (1990-98). An average of 834,000 people, many of them working families and children, are expected to receive publicly funded medical assistance during the 2001-03 biennium. This is a 53,000 person (7 percent) increase over the prior two-year budget period.[10]

As noted earlier, this growth in eligibility has been the result of targeted expansionary efforts during times of lower health care costs and more state funding. Areas with the largest increases in eligibility for medical assistance have been routine and preventive care for CN children, CN & MN senior citizens and MN blind and disabled persons.[11] The extension of medical services has been accompanied by a significant reduction in the uninsured rate[12] in Washington State and greatly increased expenditures.

Certainly, these increased expenditures can, in part, be tied to the Department's efforts to extend medical services to more people. Expenditure growth may however, also be caused by the extension of coverage to persons who require and use expensive services. Figure Three shows annual per capita expenditures for several categorical groups. One can see the per capita expenditures associated with providing medical services for pregnant women, the elderly, blind and disabled exceeds by more than twice the average per capita expenditures. To learn more about what is driving expenditures upward, it is necessary to look at the mandatory and optional services inside the Medical Assistance programs.

[10] Budget Division, Office of Forecasting & Policy Analysis, April 2001. Department of Social & Health Services, Olympia, Washington.
[11] Expenditures for children account for 31 percent of MAA expenditures ($600 million, annually). Expenditures for CN-elderly account for 9 percent of MAA expenditures. Overall, 70 percent of MAA expenditures are for mandatory and optional services in the CN mandatory program. Optional services account for 24 percent of the expenses for the CN mandatory program.
[12] Washington State Population Survey 2000. Office of Financial Management, July 2001.

Growth in Annual Per Capita Expenditures for Selected Programs FY96-03

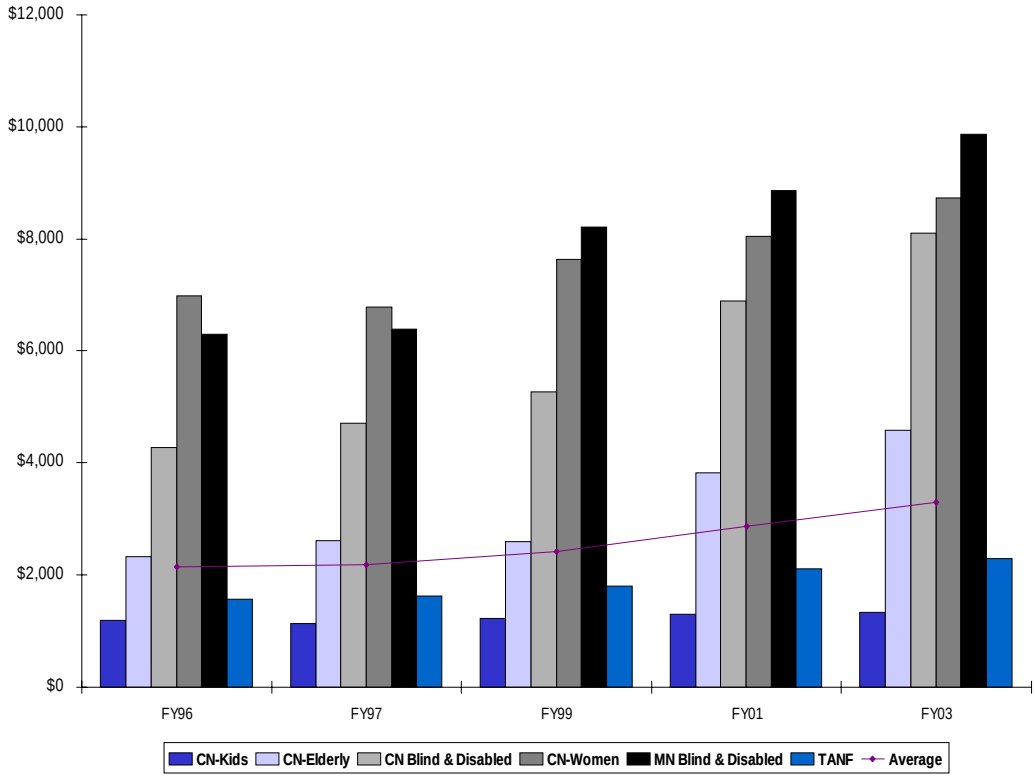


Figure Three

Historically, the program granting Temporary Assistance for Needy Families (TANF - formerly AFDC) has been the largest of the MAA programs. Once a program providing medical services to 320,000 persons -- representing 47 percent of the total caseload (FY96) – eligibility has decreased to 270,000, 110,000 of them children (FY01). With the softening of the economy and much higher unemployment levels, eligibility is forecasted to increase an additional 3 percent each year during the 01-03 biennium. The TANF program represents 38 percent of enrollment and 26 percent of the expenditures (FY01). Led by increases in prescription drugs (up 186 percent), managed care for delivery assistance (up 67 percent), inpatient hospitalization (up 64 percent) and physician services (up 60 percent), expenditures for this group have increased by 17 percent between FY96-01. Expenditures are forecasted to increase from $585 to $700 million (20 percent) during the 01-03 biennium.

Eligibility for the CN program for children has increased 12.5 percent annually from 163,000 to 294,000 from FY96-01, and eligibility is forecasted to increase an additional 7.5 percent during the 01-03 biennium. The children's program represents 35 percent of the enrollment and 18 percent of the expenditures (FY01). Led by increases in managed care (up 167 percent), dental services (up 181 percent), home health care (up 123 percent) and transportation services (up 116 percent), expenditures for this group have increased by 120 percent between FY96-01. Expenditures are forecasted to increase from $420 to $451 million (7.4 percent) during the 01-03 biennium.

Eligibility for the CN program for the elderly has increased from 38,000 to 52,000 from FY96-01, and eligibility is forecasted to increase an additional 4.5 percent during the 01-03 biennium. As our citizenry age, this group (and blind and disabled) will be likely to expand considerably during the next two decades. Enrollment in this group represents 6 percent of the total and 9 percent of the expenditures (FY01). Medicare also covers nearly 85 percent of the people in this group. Led by increases in outpatient services (up 190 percent), home health care (up 186 percent), transportation services (up 172 percent), prescription drugs (up 166 percent) and medical equipment (up 140 percent), expenditures for this group have increased by 139 percent between FY96-01. Expenditures are forecasted to increase from $214 to $252 million (18 percent) during FY01-03.

Eligibility for the CN program for the blind and disabled has increased from 95,000 to 104,000 persons from FY96-01, and eligibility is forecasted to increase an additional 6.4 percent during FY01-03. Enrollment in this group represents 12.5 percent of the total and 31 percent of total expenditures (FY01). About 23 percent of the people in this group also receive coverage under Medicare. Led by increases in prescription drugs (up 158 percent), dental (up 98 percent), home health care (up 97 percent), transportation services (up 84 percent), and outpatient services (up 71 percent), expenditures for this group have increased by 79 percent between FY96-01. Expenditures are forecasted to increase from $727 to $936 million (29 percent) during the 01-03 biennium. During the 2001 session of the Legislature, a program was enacted to extend Medicaid coverage to the working disabled. Coverage is extended to persons with income up to 450 percent of FPL. Estimates suggest that 1,100 people will qualify for this program. This program permits cost-sharing up to 5 percent of adjusted income.

Extending medical services to pregnant women and their newborn children, the CN program for low-income women has increased eligibility from 19,000 to 22,565 persons from FY96-01. Eligibility is forecasted to remain stable during the FY01-03 budget period, but expenditures are forecasted to increase from $183 to $217 million (18 percent). Enrollment in this group represents 3 percent of the total and 7.8 percent of total expenditures (FY01). Led by increases in home health care (up 161 percent), dental services (up 128 percent), prescription drugs (up 94 percent), managed care for

delivery assistance (up 65 percent) and medical equipment (up 50 percent), expenditures for this group have increased by 38 percent between FY96-01.

Eligibility for the medically needy (MN) program for the elderly has increased from 4,295 to 6,294 from FY96-01, and eligibility is forecasted to increase an additional 15 percent during the 01-03 biennium. As our citizenry age, this group (and blind and disabled) will be likely to expand considerably during the next two decades. Led by increases in outpatient services (up 147 percent), home health care (up 130 percent), prescription drugs (up 118 percent), dental care (up 115 percent) and inpatient services (up 106 percent), expenditures for this group have increased by 105 percent between FY96-01. Expenditures are forecasted to increase from $20.8 to $23 million (10.5 percent) during the 01-03 biennium.

Eligibility for the MN program for the blind and disabled has increased from 5,576 to 8,060 persons from FY96-01, and eligibility is forecasted to increase an additional 6 percent during the 01-03 biennium. Led by increases in prescription drugs (up 161 percent), dental care (up 141 percent), other medical services (up 86 percent), outpatient services (up 88 percent) and inpatient services (up 60 percent), expenditures for this group have increased by 92 percent between FY96-01. Expenditures are forecasted to increase from $61.3 to $81.7 million (19 percent) during the 01-03 biennium.

Driven by demand for coverage and mounting expenditures for a variety of services, it is anticipated the state will spend over $6 billion for medical services during the 2001-03 biennium – exceeding by almost $1.5 billion, an increase of 32 percent, the amount spent for these same services during the 1999-01 biennium (see Figure Four). Since FY96, expenditures have risen 9.8 percent annually. Expenditures for Medical Assistance programs have grown from 29 percent of the Department's expenditures in FY96 to represent 42 percent of the Department's total budget during the 2001-03 biennium.

Expenditure Growth for Medical Services FY96-03

Fiscal Year	Total	Inpatient	Drugs	Durable Equipment	Transport	Optional Groups	Optional Services
1996	**$1,589,113,420**	**$ 286,264,467**	**$ 182,926,060**	**$ 32,497,392**	**$ 26,715,821**	**$ 130,224,516**	**$ 355,068,416**
1997	**$1,770,724,946**	**285,011,610**	**207,111,907**	**35,844,772**	**28,780,949**	**137,274,672**	**397,707,781**
	111.43%	99.56%	113.22%	110.30%	107.73%	105.41%	112.01%
1998	**$1,864,398,431**	**290,447,009**	**242,270,491**	**40,555,104**	**32,735,327**	**153,019,971**	**433,674,496**
	117.32%	101.46%	132.44%	124.79%	122.53%	117.50%	122.14%
1999	**$1,928,256,857**	**332,254,450**	**251,881,801**	**37,767,979**	**29,916,408**	**170,129,623**	**442,178,344**
	121.34%	116.07%	137.70%	116.22%	111.98%	130.64%	124.53%
2000	**$2,333,454,400**	**362,272,421**	**377,716,289**	**52,190,920**	**41,815,631**	**161,293,149**	**526,015,442**
	146.84%	126.55%	206.49%	160.60%	156.52%	123.86%	148.14%
2001	**2,698,550,266**	**393,905,357**	**466,833,867**	**58,388,781**	**50,665,279**	**192,477,287**	**719,114,710**
	169.81%	137.60%	255.20%	179.67%	189.65%	147.80%	202.53%
2002	**3,586,739,737**	**441,648,311**	**519,626,096**	**67,012,917**	**49,459,624**	**219,875,201**	**784,953,517**
	225.71%	154.28%	284.06%	206.21%	185.13%	168.84%	221.07%
2003	**$ 3,256,427,962**	**$ 483,773,607**	**$ 584,153,681**	**$ 75,519,361**	**$ 53,597,277**	**$ 239,627,525**	**$ 867,819,759**
	204.92%	169.00%	319.34%	232.39%	200.62%	184.01%	244.41%

Figure Four

MAA has adopted several strategies to address rising cost increases for medical services. To address the increases in CY 2000 Healthy Options' rates, MAA adopted a new four-step procurement strategy for CY 2001, which relied on published rate targets and greater competition. Beginning July 1, 2002, MAA will impose a monthly premium during the second six months of transitional coverage for TANF and other families that become ineligible for a family medical program due to an increase in earned income. It is estimated that approximately 10,000 adults will pay $15 monthly premiums. MAA will also begin charging its fee-for-service adult clients an emergency room copayment for non-emergent services, effective January 1, 2002.

MAA is also undertaking a pilot disease case management program to focus coordinated care for selected conditions, like cardiovascular, diabetes, asthma, renal and cancer. Under the umbrella of utilization and cost containment, MAA will be looking very closely at improved coordination of benefits with third party and employer insurance coverage, better recoupment of payment for services, increased use of prior authorization for medical services and prescription drug management.

The Department's expenditures for prescription drugs have increased by 20 percent annually from FY96-01. In 1991, MAA implemented the federal drug rebate program, which requires Medicaid programs to purchase only from manufacturers having signed rebate agreements with the federal government. MAA has worked closely with the Washington State Pharmacists Association and has been studying ways to stem rapidly rising expenditures for prescription drugs. The Department's outlay for prescription drugs is forecasted to increase by 30 percent ($260 million) from FY99-01 to FY01-03.

MAA has attempted to adopt more effective drug purchasing strategies to address this significant increase. In January 2002, MAA will launch a therapeutic consultation program that will provide the physicians with the information needed to manage the full course of a patient's prescribed drugs, and whenever possible increase the use of generic drugs. Because expenses for prescription drugs have risen dramatically as part of elderly, blind and disabled care, MAA is also considering a primary care case management (PCCM) demonstration specifically for these clients. This demonstration will pay physicians to become a primary care provider to help manage the client's care and associated costs.

While MAA's expenditures for prescription drugs represent $520 million (20 percent) of FY02 medical assistance outlays, spending for all optional services accounts for another 10 percent ($785 million) of total outlays. Enrollment in optional health care programs has increased 37 percent from FY96, and spending for these optional populations has increased 68 percent to $220 million in FY02.

While state funding sources have been able to keep up, health care expenditure increases have reached a crisis point. Constrained by the 1993 passage of I-601, the expenditure growth factor from 1996-2001 has averaged 3.3 percent — far short of the rate of increases in health care expenditures.

Although Medicaid is undertaking a number of cost-containment initiatives, including prescription drug consultations and disease management pilots, it is quite likely that the disparate relationship between the growth in state revenue sources used to finance health care and the growth in health expenditures for low-income residents will continue for the foreseeable future. Washington State and DSHS will need to develop additional options if it is to retain the ability to sustain its health care coverage for low-income residents. The requested waiver flexibility is one of the needed options, as well as being able to use its unspent SCHIP allotment.

In response to the worsening fiscal climate in Washington State, the Governor recently required the administrators of all state agencies to submit expenditure reduction plans to lower 2001-03 biennial spending by 10 to 15 percent. Since available state revenue and health care expenditures are in opposition, this task may require the implementation of every available option.

V. DEMONSTRATION DESIGN

Washington's demonstration request is built upon its existing programs for low-income residents, and is based upon Congressional and Administration strategies to provide states greater flexibility to expand coverage to low-income children and other vulnerable populations. At the same time, the demonstration will ensure that its most vulnerable populations continue to have the essential health coverage and safeguards that have been a cornerstone of the Medicaid program. Furthermore, long-term care services under Medicaid (e.g., nursing facility, personal care, or home and community-based waiver services) are not part of the demonstration.

Unlike other 1115 state demonstrations, Washington's demonstration would request flexibility to adopt cost-sharing, benefit design changes, and enrollment limits over its life. However, the state would only adopt these provisions if they are needed to help sustain the state's ability to offer coverage to as many persons as state funding permits. The demonstration would allow the Governor and Legislature the ability to use these policy options instead of having to use the more restrictive options available under existing federal law. Instead of having to reduce eligibility coverage levels or eliminate optional eligibility groups, Washington would be able to adopt reasonable premiums to help share in the cost of coverage, or to be able to impose waiting lists. In order to help sustain coverage, Washington would be able to modify its Medicaid optional eligibility groups' benefit coverage to be more in line with the Basic Health program and the state's model benefit design for commercial coverage.

The requested programmatic flexibility is not open-ended. Washington's demonstration includes limits on the options to ensure that its vulnerable populations continue to have access to medically appropriate care. There would be limits on the amount of cost-sharing that could be imposed on clients. There also would be a "floor" on the optional benefit coverage. This floor would ensure that clients have access to preventive and comprehensive care.

These changes would require approval by the Washington State Legislature. Administration of the demonstration would include a state plan type review process wherein the Centers for Medicare and Medicaid Services (CMS) would review the proposed changes before implementation to ensure that they are consistent with the demonstration waiver's terms and conditions.

Core Vulnerable Population Coverage

The federal government has defined a core population that states must guarantee coverage in order to participate in the Medicaid program. These mandatory populations are prescribed under categorical groups in the Medicaid Categorically Needy mandatory program (see Attachment A for a description of Washington's Mandatory eligibility groups).

Consistent with longstanding federal policy and requirements and the NGA HR-32 policy, Washington's demonstration waiver would continue to guarantee eligibility and meet federal benefit coverage requirements for its existing Categorically Needy mandatory eligibility groups. The only change requested under the demonstration for mandatory groups would be to allow for adoption of reasonable copayment requirements for optional service benefits to all mandatory groups, and premiums for persons in families above 100 percent of FPL. **[NOTE: In order to maximize the state's flexibility and reduce complexity, it is recommended that the copayment provisions be revised to allow the state to impose copayments on all non-preventive services for both Mandatory and Optional groups.]**

Cost-Sharing

Historically, Medicaid was intended to serve certain vulnerable low-income populations, whose incomes were for the most part below the federal poverty level. Over time, the federal government has sought to expand health coverage to groups with higher income levels through the Medicaid optional programs, Medically Needy program, and the State Children's Health Insurance Program (SCHIP). These expansions have included provisions to give states flexibility to adopt reasonable premiums.

For some time, the federal government has given states the option to impose premiums on families who have left TANF grant assistance and who are receiving Transitional Medical Assistance (TMA) coverage during the second six-months of the transitional coverage. States also have been able to adopt premiums for coverage of pregnant women and infants in families with incomes above 150 percent of FPL. Furthermore, states also have been able to adopt "nominal premiums" for persons seeking coverage through the Medically Needy program.

The Health Care Financing Administration (now CMS) has also given certain waiver demonstration states flexibility to adopt premium requirements for children's optional coverage groups.

As part of the federal partnership with states to offer health coverage to low-income children up to at least 200 percent of FPL, Congress enacted SCHIP. This partnership

included giving states more flexibility to design coverage for these populations. This included allowing states to adopt reasonable premiums for coverage. CMS recently enacted SCHIP regulations allowing states to adopt reasonable premiums and copayments for children in families above the FPL, as long as the total amount does not exceed 5.0 percent of the families' total income.

As Medicaid optional coverage has been made available to persons with higher incomes, states have been given more flexibility to utilize client cost-sharing. The Medicaid Buy-In program allows states to adopt premiums for coverage. The law sets an upper limit of 7.5 percent of income for individuals with incomes up to 450 percent of FPL. Premiums for persons above this income level can be greater, and a state is required to charge the full amount of Medicaid costs for their care if their income exceeds $75,000.

The Administration's recently announced HIFA demonstration initiative, which is intended to expand Medicaid coverage options for persons up to 200 percent of FPL, incorporates provisions to give states more flexibility to define cost-sharing for both Medicaid optional populations and for new expansion populations. HIFA allows states to adopt copayment and premium provisions for Medicaid optional and SCHIP children as long as the children's cost-sharing does not exceed 5.0 percent of the family's income. The amount can be greater when coverage includes the entire family.

The SCHIP and HIFA cost-sharing requirements are also consistent with the NGA's HR-32 policy. HR-32 would allow states to adopt cost-sharing consistent with SCHIP's 5.0 percent of family income standard.

Washington's Medicaid program is adopting target premium coverage requirements. Beginning in July 2002, adults receiving Transitional Medical Assistance (TMA) coverage during the second six-months of the transitional coverage will be required to pay a premium for coverage. The state's Medicaid Buy-In program also will require premium and enrollment fee participation towards coverage.

Washington's demonstration waiver builds upon national policy and its initial Medicaid efforts. Under the demonstration, affordable copayments could be adopted for optional services to all Mandatory eligibility groups, including non-emergency services provided in hospital emergency rooms. For all Optional eligibility groups, copayments could be imposed for all non-preventive care services. **[NOTE: In order to maximize the state's flexibility and reduce complexity, it is recommended that the copayment provisions be revised to allow the state to impose copayments on all non-preventive services for both Mandatory and Optional groups.]** Premiums could be adopted for all Mandatory and Optional eligibility groups for persons in families with incomes above 100 percent of FPL. However, total cost-sharing would not exceed, on average, more than 5.0 percent of a family's total income.

Benefit Package Flexibility

The Medicaid program gives states broad latitude to design their own benefit package, except for children's coverage due to EPSDT. The Medicaid Categorically Needy program has a limited set of eight mandatory service requirements.[13] States are able to offer a variety of medical, behavioral health and long-term care services to Categorically Needy eligibility groups. The Medicaid program provides states even broader benefit package flexibility for their Medically Needy programs.

There are two requirements that significantly impact states' benefit package flexibility. Under comparability of service requirements, states are required to offer the same set of benefits to all Categorically Needy mandatory and optional eligibility groups. They cannot offer one set of services to one Medicaid CN population and another set to other CN groups.

Second, under EPSDT requirements, states are required to provide all services identified in an EPSDT screen as medically necessary, regardless of it being a covered service or not. Given that children represent the largest eligibility group under Medicaid (nearly 65 percent of Washington's Medicaid clients are children), EPSDT effectively limits state's benefit design flexibility for the majority of its enrollees.

Congress and HHS have recognized the need to give states more flexibility in designing benefit coverage for children and other groups with income above the poverty level. The SCHIP program is an example of this policy direction. States may choose from packages that include three standard offerings plus a benefit package that is actuarially equivalent to one of the three packages.[14]

There also are provisions in federal law that allow the Secretary of HHS to approve coverage that is appropriate for children in families below 200 percent of poverty. The SCHIP law requires that any benefit design must include: inpatient and outpatient hospital services; physicians, surgical and medical services; laboratory and x-ray services; and well-baby and well-child care, including age appropriate immunizations.

---

[13] The Medicaid CN mandatory services include: inpatient hospital services; outpatient hospital services; other laboratory and x-ray services; physician services and medical and surgical services of a dentist; nursing practitioners' services; nurse-midwife services; rural health clinic (including federally qualified health care center) services; nursing facility (NF) services and home health services for individuals age 21 and older; early and periodic screening, diagnosis and treatment (EPSDT) for individuals under age 21; and family planning services and supplies.

[14] SCHIP benchmark plans are: standard Blue Cross/Blue Shield preferred provider option (PPO) offered to federal employees; health benefits offered to state employees; or largest commercial benefit package offered by health carrier in the state. There also are provisions in federal law, which allow the Secretary of the Department of Health and Human Services (HHS) to approve coverage that is appropriate for children in families below 200 percent of poverty

The HHS HIFA demonstration waiver would allow states the same SCHIP benefit package flexibility for Medicaid optional eligibility groups. The HIFA demonstration waiver allows for even more flexibility for expansion groups, such as childless non-disabled adults.

An important component in the SCHIP and HIFA demonstrations is that states do not have to comport with comparability of service requirements. This allows states to tailor benefit packages to different populations. Although states are required to offer well-baby and well-child preventive care coverage, they do not have to comport with EPSDT requirements.

The NGA HR-32 policy also acknowledges states' need for benefit design flexibility under both its Category 2 and Category 3 populations. Under the NGA policy, states would receive enhanced SCHIP match for populations receiving benefits actuarially equivalent to the SCHIP models, and would receive standard Medicaid match for populations receiving less comprehensive coverage.

Washington's demonstration waiver for benefit design flexibility is consistent with benefit flexibility under SCHIP and HIFA. Under its demonstration, Washington would be able to offer different benefit designs to its Medicaid mandatory and optional eligibility groups and SCHIP. In order to achieve this flexibility, the demonstration waiver would waive comparability of service requirements and EPSDT requirements for optional eligibility groups. However, there would be a benefit design floor actuarially equivalent to the states' Basic Health (BH) benefit design, without its preexisting condition limitations, and with the added coverage of outpatient rehabilitation therapies. This floor would apply to both mandatory and optional eligibility groups, but long-term care services under Medicaid would not be affected by benefit design changes under the demonstration.

Under the demonstration waiver, the benefit design floor could be changed if the state changes the current BH benefit design. The proposed benefit design floor would always be equal to or greater than either the Medicaid CN mandatory benefits without EPSDT obligations or the minimum benefit designs allowed under SCHIP and HIFA Secretary-approved benefit packages. Washington would retain flexibility under current federal law to change optional services not covered by BH for mandatory populations.

Attachment C includes an actuarial benefit analysis that compares the benefit design floor with the state's Uniform Medical Plan (UMP), which is a health benefits coverage plan offered and generally available to all Washington State employees, and the minimum benefit design specified in SCHIP and the HIFA demonstration initiative. This analysis indicates that the Medicaid waiver's benefit floor has an aggregate actuarial value that is at least equivalent to the UMP and the SCHIP and HIFA basic services requirements. This is also the case when the state's SCHIP copayments are applied to the benefit floor.

Enrollment Limits

Medicaid is an entitlement program. As an entitlement program, Medicaid does not allow states to impose enrollment limits due to limits on available state matching funds. Although states cannot impose enrollment limits on Medicaid coverage, they can limit coverage only to so-called mandatory groups. They also have flexibility to change eligibility standards for optional groups. This situation results in having to disenroll persons covered under the program who have higher income or resources than allowed under the revised coverage limits. As optional programs have been expanded to cover more vulnerable groups (e.g., working disabled or women with breast or cervical cancer), this approach may hurt those currently receiving needed care.

Congress recognized the need to give states more flexibility when they implemented SCHIP, which allows states to offer coverage on a non-entitlement basis. States have recognized the need to adopt enrollment limits with their state-only programs, such as Washington's BH program. The federal government has also recognized the need for this flexibility, by allowing states to impose enrollment limits under demonstration waivers for optional coverage groups.

Washington's demonstration waiver is seeking this same rational flexibility to administer its Medicaid optional programs. It is important to understand that this flexibility is necessary to sustain the major commitments that Washington has already made to cover optional groups.

To comport with the federal intent of the Medicaid program and ensure coverage to its most vulnerable residents, the demonstration would continue to guarantee coverage for its mandatory Categorically Needy eligibility groups. The demonstration would allow Washington State to offer coverage to SCHIP and other optional eligibility groups within available state matching funds authorized by the Legislature. Washington State would be able to impose enrollment limits and waiting lists for coverage if overall expenditures were exceeding appropriation levels and available state funds were not sufficient to cover optional groups. The demonstration would also allow Washington to prioritize categorical populations that would be first subject to enrollment limits, based on legislative direction. As permitted under federal law, Washington State would remain able to eliminate coverage for optional groups.

There is a specific standard of promptness for the processing of Medicaid applications. Currently in Washington, the standard of promptness is forty-five days (not including those applications for pregnant women and disability determinations). When enrollment limits are in place, the applications will still be processed within the required time frames

to determine eligibility for all Medicaid programs. If eligibility is for an optional group that is subject to a waiting list:

- The application will be pended;
- The applicant will receive notification;
- The date of eligibility will be the first of month the applicant reaches the top of the waiting list; and
- The applications will be processed based on the date of application (first on – first off), regardless of medical need.

With the implementation of enrollment limits, there also would be a limited change with respect to retroactive eligibility under Medicaid. There would be no prior month(s) retroactive coverage for an optional group that is subject to a waiting list. When there is a waiting list, coverage would start the first of the month that an applicant reaches the top of the waiting list and becomes eligible. When enrollment limits are removed, coverage for applicants would start the first of the month. For applicants who apply after enrollment limits are removed, their retroactive eligibility would be considered first looking back to the effective date of enrollment limits being removed, before considering regular retroactive eligibility under Medicaid.

Coverage for Parents with Medicaid and SCHIP Children

Washington's demonstration waiver would allow the state to use its unspent Title XXI allotment funds to expand coverage to parents with Medicaid and SCHIP children, and childless adults on a lower priority basis. This coverage would be through the existing BH program. These parents will have the same benefit coverage and cost-sharing requirements as other BH enrollees, including preexisting condition limitations. Expansion would begin in January 2003, or as soon as administratively possible thereafter.

Attachment D includes an actuarial benefit analysis that compares the BH benefit design with the state's UMP. This analysis indicates that the Medicaid waiver's benefit floor has an aggregate actuarial value that is at least equivalent to the UMP, and that the BH benefit design comports with both Title XXI and HIFA benefit design requirements.

Under the waiver, Washington would use its unspent Title XXI allotment to leverage existing state Health Services Account funds to expand coverage for these parents and childless adults. Parents would be the prioritized population. Attachment E provides state estimates on the amount of unspent Title XXI allotted funds that would be available to expand coverage to these groups. The estimates indicate that the state

would have $106 million in unspent Title XXI funds during FFY 2002, $90 million in FFY 2003 and 2004, and over $100 million per year thereafter, after taking into account projected SCHIP expenditures.

It is estimated that there are about 32,000 parents enrolled in BH with children enrolled in the Medicaid financed BH+ program. The use of Title XXI funding to help finance their coverage would allow the state to offer coverage to an additional **XX,XXX** parents or childless adults. This would represent a **XX** percent increase in BH's enrollment capacity, and potentially increase parental enrollment by **XX** percent. Attachment F provides cost estimates for this coverage. **[NOTE: Final estimate being developed.]**

The state will be able to offer this additional coverage plus its projected SCHIP children's coverage within its annual Title XXI allotment.

VI. REQUESTED WAIVERS

Copayments

Washington State requests a waiver of section 1902(a)(14) that provides that enrollment fees, premiums, or similar charges, and deductions, cost-sharing, or similar charges, may be imposed only as provided in section 1916. The demonstration would allow affordable copayments to be imposed on all non-preventive services for optional eligibility groups. For mandatory eligibility groups, copayments would not be imposed on mandatory services, except for non-emergent use of hospital emergency rooms. Affordable copayments could be imposed on all optional services for mandatory eligibility groups. **[NOTE: In order to maximize the state's flexibility and reduce complexity, it is recommended that the copayment provisions be revised to allow the state to impose copayments on all non-preventive services for both Mandatory and Optional groups.]**

Washington State also requests a waiver of section 1916(e) that provides that the State Plan shall require that no provider participating under the State plan may deny care or services to an individual eligible for such care or services under the plan on account of such individual's inability to pay a deduction, cost-sharing, or similar charge. This request would permit providers the ability to limit or deny care when copayments are not paid at the time of service, but it would not extinguish the liability of the individual to whom the care or services were furnished for payment of the deduction, cost-sharing, or similar charge.

In accordance with Washington's tribal accord and federal SCHIP policy, a waiver of Section 1902(a)(14) would also assure that copayments would not be imposed on American Indians or Alaska Natives.

Premiums

Washington State requests a waiver of section 1902(a)(14) that provides that enrollment fees, premiums, or similar charges, and deductions, cost-sharing, or similar charges, may be imposed only as provided in section 1916. Washington State also requests a waiver of sections 1902(e)(1)(B) and 1925(b)(5) regarding the 3 percent premium limitation for transitional medical assistance. Washington State further requests a waiver of Section 2103(e) to the extent that SCHIP individuals below 150 percent of poverty may be affected. The demonstration would allow reasonable premiums to be imposed for medical coverage on all Medicaid clients with income above 100 percent of poverty. However, total Medicaid or SCHIP cost-sharing (premiums plus point-of-service cost-sharing) for health related care for DSHS clients would not exceed, on average, 5 percent of the family's income.

In accordance with Washington's tribal accord and federal SCHIP policy, a waiver of Section 1902(a)(14) would also assure that premiums would not be imposed on American Indians or Alaska Natives.

Benefit Package

Washington State requests a waiver of section 1902(a)(10)(A) that provides that certain services must be available for all categorically needy individuals (both mandatory and optional individuals) and a waiver of section 1902(a)(10)(B) that provides that medical assistance made available to any individual described in subparagraph (A) of section 1902(a)(10) –

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A).

Washington State also requests a waiver of section 1902(a)(10)(C) to the extent that it relates to comparability of services for the medically needy, and any other provisions of section 1902(a)(10) regarding service requirements, to allow the flexibility intended under the demonstration.

Washington State requests a waiver of section 1902(a)(43)(C) for optional eligibility groups regarding EPSDT and services that must be provided under the Medicaid State Plan, particularly arranging for corrective treatment, whether or not such services are covered under the State Plan. Under the demonstration, formal EPSDT requirements would be eliminated, and well-baby and well-child care would be provided, including age-appropriate immunizations.

As described in Section V on Demonstration Design, the demonstration waiver would offer additional coverage to parents with Medicaid and SCHIP children, and childless adults, through the BH program. Washington State further requests a waiver of section 2103(a) regarding SCHIP benefit design and section 2103(f) regarding retention of preexisting condition limitations under the BH program.

The demonstration would retain existing mandatory benefits for mandatory eligibility groups, as defined in federal Medicaid statute. This would still allow Washington to retain flexibility under current federal law regarding optional services for mandatory populations.

For optional eligibility groups, the demonstration would waive mandatory service requirements, including EPSDT, for all Medicaid optional groups and SCHIP. Also, it would waive comparability of service requirements for Medicaid CN mandatory and CN optional groups, and among optional groups. This would allow Washington to have different benefit designs for its various eligibility groups.

The demonstration would establish a benefit design floor that would be actuarially equivalent to the state's Basic Health (BH) benefit design, without its preexisting condition limitations, and with the added coverage of outpatient rehabilitation therapies. The floor could be adjusted for changes in the scope of BH program benefit design. However, the benefit design floor would always be equal to or greater than either the Medicaid CN Mandatory benefits without EPSDT obligations or the minimum benefit designs allowed under SCHIP and HIFA Secretary-approved benefit packages.[15] Washington would retain flexibility under current federal law to change optional services not covered by BH for mandatory populations.

Enrollment Limits

Washington State requests a waiver of section 1902(a)(8) that provides that all individuals have the opportunity to apply for medical assistance and that such assistance shall be furnished with reasonable promptness. A further waiver of section 1902(a)(10) is requested to the extent that its provisions may impair the ability to

[15] This benefit package would include the following services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care.

impose enrollment limits. A waiver of section 1902(a)(34) is also requested to the extent that there would be no prior month(s) retroactive Medicaid eligibility and coverage for an optional group that is subject to a waiting list.

The demonstration would continue to guarantee coverage for its mandatory Categorically Needy eligibility groups. The demonstration would allow Washington State to offer coverage to SCHIP and other optional eligibility groups within available state matching funds authorized by the Legislature. Washington State would be able to impose waiting lists for coverage if state funds were not sufficient to cover optional groups. The demonstration would allow Washington to prioritize categorical populations that would be first subject to enrollment limits.

Washington State also requests that CMS grant any other waiver deemed necessary to implement the demonstration as described herein. **In addition to waiving these program restrictions, Washington State requests authorization under Section 1115(a)(2) to claim federal financial participation for expenditures that otherwise would not be eligible for federal match under sections 1903(m) and 2105(c)(3) and other provisions of Title XIX and Title XXI. Such expenditures could include Title XIX expenditures related to coverage of individuals for whom cost-sharing rules not otherwise allowable in the Medicaid program apply, and Title XXI expenditures to provide services to populations not otherwise eligible under a State Child Health Plan.**

VII. PROGRAM AND DEMONSTRATION ADMINISTRATION

Single State Agency

DSHS is designated as the single state agency for the Medicaid and SCHIP programs in Washington State and is organized with several administrations responsible for different federal and state programs serving residents of the state. (See Attachment G for an organizational chart of DSHS.) Its mission is to improve the quality of life for individuals and families in need and to help people achieve safe, self-sufficient, healthy and secure lives.

Within DSHS, Medical Assistance Administration (MAA) is designated as the medical assistance unit for the Medicaid program. MAA administers Medical Assistance and the SCHIP programs to maximize opportunities for low-income people to obtain quality health services. (See Attachment G for an organizational chart of MAA.) The focus of MAA is on medical services and other administrations of DSHS have responsibility for

long-term care (community-based or institutional care) and behavioral health services under the Medicaid State Plan.

Program Administration

MAA would be responsible for implementing and managing this demonstration waiver. MAA would administer the demonstration in coordination with the state Health Care Authority (HCA) and other administrations within DSHS. There are administrative activities that MAA would be required to conduct to implement and monitor the options proposed in this demonstration.

MAA is positioned to administer cost-sharing options based on activity now under way to implement emergency room copayment and Transitional Medical Assistance premium requirements incorporated in the current biennial budget, including the means to determine clients' income relative to the federal poverty level. However, any cost-sharing requirements would require legislative approval.

The implementation of benefit package changes authorized by the Legislature is also within the scope of MAA's current administrative capability. MAA has implemented legislatively directed benefit expansions and contractions in its fee-for-service system, and has altered benefit coverage with its managed care contractors.

With the option of enrollment limits, Washington State would be able to impose limits on all optional Medicaid eligibility groups (e.g., optional children, MN elderly and disabled, Medicaid Buy-In and women with breast and cervical cancer), as well as state-administered programs, if overall expenditures were exceeding appropriation levels. MAA would need to develop the internal mechanisms to implement this option, including emergency public notification.

Demonstration Administration

In order to ensure legislative direction and stakeholder consultation, the demonstration waiver would adopt a prospective Medicaid State Plan amendment type approach. Under this model, DSHS would not adopt cost-sharing or benefit changes without approval from the Washington State Legislature. DSHS would submit the legislative changes to the Centers for Medicare and Medicaid Services (CMS) for review and approval 90 days prior to implementation to ensure that they are consistent with the demonstration's terms and conditions. If authorized by the Legislature, DSHS could impose enrollment limits when expenditures were projected to exceed the appropriated amount. If enrollment limits were implemented, DSHS would issue an emergency public notification and demonstration waiver notice to CMS.

VIII. DEMONSTRATION EVALUATION

Demonstration Goals

Washington's 1115 demonstration's goals are to:

- Have enhanced flexibility to design and administer its Medicaid program to sustain health coverage for its low-income residents.

- Use its unspent SCHIP allotment to help expand coverage for uninsured parents with Medicaid and SCHIP children.

Demonstration Objectives

1. To promote appropriate utilization of health care services through the use of appropriate and affordable copayments levels for both Medicaid and other Medical Assistance beneficiaries.

2. To adopt reasonable premiums that would help in the state's efforts to sustain access to health care by extending available state funds to cover as many persons as possible through Washington's existing Medicaid optional programs.

3. To promote individuals' participation in the cost of their health care coverage through the adoption of reasonable premiums.

4. To adopt flexibility to define benefits that would result in more consistency across state-subsidized programs, while promoting good health outcomes.

5. To ensure continued access to health care for those beneficiaries already enrolled in a Medicaid program by establishing waiting periods that would ensure public funds are targeted to the state's most vulnerable residents.

6. To increase coverage for low-income families with relatively higher incomes by offering state-subsidized health coverage to parents of Medicaid and SCHIP children.

Demonstration Evaluations

A demonstration evaluation design proposal will be submitted to CMS as part of the waiver plan amendment process when a waiver component (copayments, premiums, benefit changes, enrollment limits) is implemented. Each evaluation would be designed to specifically track changes in two significant areas: program participation and health care outcomes. Moreover, each evaluation would include: (1) either the hypotheses or evaluation questions; (2) study or research design; and (3) schedule for conducting the analysis and reporting findings to CMS.

Following are brief examples of evaluation themes that could be included in an evaluation proposal.

1. Hypotheses & Evaluation Questions

Hypotheses

(a) Establishing appropriate and affordable copayment levels will promote appropriate utilization of health care services and maintain good health care outcomes.

(b) Establishing reasonable premiums will help sustain access to health care.

(c) Flexibility to define benefits will result in programmatic consistency across state-subsidized programs.

(d) Replacing EPSDT requirements with more flexible well-baby and well-child care requirements will not reduce immunization rates or other primary or preventive care to children.

(e) Establishing waiting periods will ensure public funds are targeted to the most vulnerable and ensure continuity of care for those beneficiaries already enrolled.

(f) Offering family coverage will increase coverage for low-income families with relatively high income.

Copayments

(a) What impact do copayments have on utilization of services with copayments?

(b) Are there differences in managed care and fee-for-service copayment services' utilization rates?

(c) Do providers successfully collect copayments? Are there differences in collection rates between beneficiaries in managed care versus fee-for-service?

(d) Is there a decrease in providers willing to accept Medicaid beneficiaries because of copayment requirements?

(e) Do copayments influence decisions of beneficiaries to utilize services?

(f) What do beneficiaries consider reasonable/affordable copayment amounts?

Premiums

(a) Is there a change in Medicaid beneficiaries' risk-profile due to premium requirements?

(b) Do persons who elect to disenroll use less health services on average while on Medicaid, and are thus more willing to forego insurance coverage and incur out-of-pocket costs for health care?

(c) Do persons who elect to disenroll have more resources or potentially more income, and are thus more willing to pay out-of-pocket costs for health care?

(d) Do persons who disenroll do so voluntarily?

(e) Have persons who disenrolled encountered an event(s) that limited their financial ability to make their monthly payment?

(f) What is the difference in drop out rates between family coverage and children only coverage?

(g) How do Medicaid drop out rates compare to drop out rates in the Basic Health program?

Benefit Design

(a) Does replacing EPSDT requirements with more flexible well-baby and well-child care requirements affect children's immunization rates?

(b) Would a redefined benefit design decrease the number of emergency room visits for children with asthma?

(c) Would a redefined benefit design decrease the number of children hospitalized for dehydration?

(d) Would a redefined benefit design decrease the number of emergency room visits for adults with heart disease?

(e) Would a redefined benefit design decrease the number of adults hospitalized for diabetes?

Enrollment Limits

(a) What is the demographic profile of beneficiaries on waiting lists?

(b) Is there a change in Medicaid beneficiaries' risk-profile due to enrollment limits?

(c) How do beneficiaries receive health care while on a waiting list?

Title XXI SCHIP Expansion

(a) Does offering coverage to the entire family increase children's SCHIP enrollment?

(b) Does offering coverage to the entire family increase higher income Medicaid enrollment of children?

(c) Does offering coverage to the entire family increase higher income BH enrollment?

(d) Are there better health outcomes (e.g., immunization rates, CAHPS utilization measures) for children whose parents have health insurance compared to Medicaid/SCHIP children whose parents don't have coverage?

(e) Is there a reduction in the state's proportion of uninsured adults below 250% of the federal poverty level?

(f) Is there a reduction in the state's proportion of uninsured children below 250% of the federal poverty level?

2. Study & Research Design

Analysis of Hospitalizations among Medicaid Recipients

Baseline health outcome measures could be developed to track and measure changes in the health status of beneficiaries after implementation of a waiver component. Specifically, the following ambulatory sensitive hospital conditions would be measured and tracked: Pneumonia; Congestive heart failure; Asthma; Cellulitis; Perforated or bleeding ulcer; Pyelonephritis; Diabetes with ketoacidosis or coma; Ruptured appendix; Malignant hypertension; Hypokalemia; Immunizable conditions; and, Gangrene (Source: L. Jean Kozak, National Center for Health Statistics, Hyattsville, MD.)

Baseline measures could be developed using the following methods and procedures:

1. Obtain two most recent complete years of Medicaid claims data merged with program eligibility and demographic data from the DSHS' Automated Client Eligibility System (ACES) and the Department of Health's Charges by Diagnosis Related Group (CHARS) database.

2. Use ICD-9-CM diagnosis codes cited in the research literature as representing conditions for which hospital admissions should be preventable with adequate ambulatory care. Use these definitions to identify avoidable hospitalizations by disease/condition.

3. For individuals with avoidable hospitalizations, provide detailed information on previous and subsequent use of other health care services, co-morbid conditions, and demographic information. Where feasible, compare this information to individuals who do not have avoidable hospitalizations (simple statistical tests, multivariate analysis) to identify significant differences between the two groups.

Surveys

Surveys would be employed to measure and track the self-reported health status of beneficiaries; and the impact and perceptions of cost-sharing, both point-of-service and premiums, by beneficiaries.

One survey already in use for self-reporting health status is the SF-36. This survey would be given to beneficiaries on a waiting list to establish a baseline and then given periodically to track trends in health status as compared to baseline findings.

3. Schedule for conducting the analysis and reporting findings to CMS

As previously discussed, a demonstration evaluation proposal would be submitted as each waiver component is implemented. The proposal would outline a schedule for both conducting the analysis and reporting analysis findings to CMS.

IX. BUDGET AND ALLOTMENT NEUTRALITY

Title XIX Budget Neutrality

Washington State's demonstration waiver comports with CMS budget neutrality requirements by ensuring that the demonstration is not expected to cost the federal government more in Title XIX federal financial participation (FFP) than without the demonstration. These assurances are made because the demonstration would not cover services that are not otherwise allowed and matchable under Title XIX. The demonstration also would not cover eligibility groups that are not otherwise allowed and matchable under Title XIX.

If the demonstration waiver's programmatic options are adopted during the demonstration period, they should reduce the costs that the federal and state governments would otherwise incur without the demonstration. The adoption of cost-sharing (copayments or premiums) or benefit design reductions are intended to reduce the per-capita costs for eligibility groups covered under the demonstration below what would be expected without the demonstration. If adopted during the demonstration period, enrollment limits for optional coverage groups covered under the demonstration would reduce the caseload below what would be expected without the demonstration.

Given these conditions, Washington requests that its demonstration waiver not be subject to annual FFP limits based on pre-defined annual per-capita cost limits, or caseload limits.

Title XXI Allotment Limits

Washington assures that Title XXI FFP for its SCHIP children's program and the coverage for parents of Medicaid or SCHIP children will not be greater than the state's annual allotment amounts.

Attachment E includes SCHIP allotment and expenditure projections for FFY 1998 through 2007. These estimates demonstrate that Washington would have unspent SCHIP allotment funds for each year.

Attachment F includes both SCHIP projections and BH coverage financed by the state's HSA and Title XXI matching funds. These estimates demonstrate that Washington would be able to finance its SCHIP plus additional BH capacity within its projected annual Title XXI allotment.

X. OTHER ASSURANCES

Washington's demonstration waiver will use its Title XXI allotment funds to claim for health care coverage provided to parents of Medicaid and SCHIP children. This coverage will be provided through the state-funded Basic Health (BH) program. Title XXI funds will be used to cover both parents currently receiving BH coverage and new parents, and possibly childless adults, over the demonstration life of the waiver. Washington assures that premium collections permitted under the demonstration will be used to reduce overall Title XIX and Title XXI program expenditures before the state claims federal match.

Unless authorized under federal law, Washington's demonstration waiver will not result in changes to the rate for federal matching payments for program expenditures. In cases where individuals are enrolled in Medicaid, SCHIP or BH programs, the Title XIX match rate will be applied to federal financial participation (FFP) for Medicaid eligibles, and the Title XXI match rate will be applied to SCHIP eligibles.

X. PUBLIC PROCESS

DSHS has taken several measures to ensure public awareness, to elicit involvement in the development of the demonstration waiver, and to comport with requirements set forth in the September 27, 1994, Public Notice as published in the Federal Register, and in the recent July 17, 2001, Dear State Medicaid Director letter.

These measures included a letter to key legislators, a press release, statewide "Community Conversations" meetings, a Government to Government consultation meeting with the tribes, an open public forum, Title XIX Advisory Committee meeting, and creation of a waiver web site at http://maa.dshs.wa.gov/medwaiver/.

Key Legislators

On August 31, 2001, key legislators were sent a letter that provided information about the Medicaid and State Children's Health Insurance Program demonstration waiver. Attached to the letter was an August 22, 2001 memorandum from Secretary Braddock that outlined the principal provisions of the waiver request.

Subsequent to the letter, DSHS staff met with key legislative staff to discuss in detail each waiver provision and to address all waiver questions and concerns.

Press Release

On September 12, 2001, DSHS released for statewide distribution an announcement of its intent to submit a demonstration waiver to CMS. The release briefly explained why a waiver is necessary and how any interested parties could find out more about the waiver and/or provide input into the waiver process by attending an open public forum, by attending a "Community Conversation" or by visiting the waiver web site.

Statewide Community Conversations

As part of DSHS strategic planning efforts, the public was asked to share its thoughts and concerns on how DSHS should improve publicly funded programs in the next seven years. Community Conversations were held statewide in two phases.

The first phase was to listen and collect public input. The second phase was to inform the public about what we heard across the state and how these ideas helped form our strategic plan.

As part of the second phase, we also used the Community Conversations to inform the public about our intent to submit a waiver, to disseminate the latest working draft waiver, and to elicit feedback. Interpreters were provided as needed.

Government to Government Consultation Meeting

On August 24, 2001, a letter was sent to the 28 Federally-recognized Tribal Governments within the state of Washington. The letter officially notified the Tribes of DSHS' intention to submit a demonstration waiver. A copy of the demonstration's latest working draft was attached for review prior to the consultation.

The notification briefly described the purpose of the demonstration waiver and requested a consultation be held in Seattle on September 5, 2001, so that waiver details could be fully explained and tribal concerns addressed.

While a majority of questions were answered during the consultation, we distributed a document informing representatives on how to contact us if they should have future concerns, questions, and/or suggestions.

Open Public Forum

On September 14, 2001, DSHS staff participated in an open public forum devoted entirely to a discussion about the demonstration waiver. The open public forum enjoyed broad participation from community health stakeholders and was sponsored by the Washington Chapter of the American Academy of Pediatrics, the Children's Alliance, Children's Hospital & Regional Medical Center, the Washington Health Foundation, and the Washington State Hospital Association.

Secretary Braddock gave a presentation that outlined provisions sought by the waiver. Attendees then had an opportunity to ask waiver-specific questions and to give comments and suggestions. Several legislators also attended and participated on a panel to give their preliminary thoughts about the waiver, and to listen to concerns and suggestions from community health stakeholders.

Although many questions and concerns were addressed at the forum, attendees were encouraged to submit comments, suggestions, and/or concerns. A document was distributed that informed attendees how to contact DSHS.

Title XIX Advisory Committee

Recognizing the value of public input into major health care decisions, the Title XIX Advisory Committee meets a federal requirement to have representation of health care stakeholders from a broad spectrum of values and backgrounds, and, most importantly, to make certain public input was collected and considered in the decision process.

In adhering to this intent, DSHS staff met with the Title XIX Advisory Committee on August 17, 2001, and on September 28, 2001. The purpose of the meetings was two-fold: to provide current demonstration waiver information, and to elicit feedback from the group.

Waiver Web Site

As a vehicle to provide as much information as possible and to elicit feedback, DSHS created a web site dedicated solely to the demonstration waiver. On the web site, the public is able to find, read and download the demonstration's latest working draft, find where the next "Community Conversations" or public meetings are to be held, read about frequently asked questions and answers, and submit any questions, comments, concerns, and/or suggestions.

The demonstration waiver web site address was widely disseminated during public meetings and also mentioned in the news release.

DSHS received more than **XX** questions for the web site. Each question and its answer was posted on the web site for public review and further comment.